MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address TX Imaging & Diagnostic Ctr. 3840 W. NW Hwy, Ste. #400 Dallas TX 75220-8115	MDR Tracking No.: M4-03-7700-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 54 TX Mutual Ins. Co. 221 W. 6th St. #300 Austin TX 78701	Date of Injury: Employer's Name: Abbott Protective Services, Inc. Insurance Carrier's No.: 99B0000276837

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6/19/02	**6/19/02**	**99070-ST & A4645**	**$361.48**	**$294.72**

PART III: REQUESTOR'S POSITION SUMMARY

6/2/03: "…We were not properly…reimbursed for the Sterile Supplies…and the Osmolar contrast…The Lumbar Discogram falls under Surgical Procedures Performed in a Doctor's Office. We meet all the requirements…we are including a letter from our nurse listing the necessary requirements…copies of our supply sheets describing charges and EOB's from various insurance companies that have paid this code in full and in accordance with TWCC Fee Guidelines…MFG/GR (V)(B)(1)…"

PART IV: RESPONDENT'S POSITION SUMMARY

7/25/03: "…The requestor billed…whole component of a CT scan associated with a discogram done on 6/19/02. In addition, requestor billed…for special supplies…and low osmolar contrast…The amount reimbursed is deemed F&R based on the documentation submitted. If a copy of the manufacturer's invoice or other pertinent information was not made available to assist our review, resources closely associated were used to determine reimbursement…TWCC MFG, RGR (I)(A)(1)(2)… documentation has not substantiated additional payment. Aside from the ground rule…a comparison of the supplies listed … do not match the supplies listed in the operative report…TWCC SGR (V)(B)(1) requires documentation of procedure if the charge is in excess of $50.00…MFG/GI (III)(A)…information available does not support additional reimbursement."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

* Both CPT codes 99070 and A4645 were denied "M- The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(B)." The respondent did not submit information to support fair and reasonable denial.

* A4645 - Requestor's documentation supported their usual and customary billing according to MFG-R/NM GR (II)(A). Five (5) examples of fair and reasonable comparative billing rendered an average of $150.00. Additional reimbursement recommended ($150.00 billed - $50.00 paid=): $100.00.

* 99070 - Requestor's documentation supported their usual and customary billing according to the MFG, SGR (V)(B)(1). Five (5) examples of fair and reasonable comparative billing rendered an average of $244.72. Additional reimbursement is recommended ($244.72 average - $50 paid=): $194.72

PART VI: DETAIL FINDINGS (If needed)

6/19/2002	99070-ST	$261.48	$194.72				
6/19/2002	A4645	$100.00	$100.00				
						Total Left Column:	$361.48
						Total Amount Due:	$294.72

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $294.72. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Carol Lawrence	03/18/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____